Name	Date
Reason for today's visit:	

Do you have or have you been treated for any of the following? (Check all that apply)

€ Arthritis € Asthma € Bleeding Disorder € Cancer (Type) _____ € Cataracts € Depression € Diabetes € Ear Disease	€ Glaucoma € Heart Disease / Heart Attack € Hepatitis € High Blood Pressure € HIV/Aids € Kidney Disease € Liver Disease € Meningitis	€ Seizures € Sickle Cell Anemia € Sleep Apnea € Stomach Ulcers € Stroke € Thyroid Disease € Transplant (Type) _____ € Tuberculosis € Other _____

HOSPITALIZATIONS

Hospitalizations: (Please list) If you need additional space please use back of this form.

DATE	REASON	HOSPITAL/FACILITY

SURGERY HISTORY

Surgeries: (Please list) If you need additional space please use back of this form.

DATE	REASON	Hospital/Facility

MEDICATIONS

Current Medications (including vitamins, herbs and over- the- counter) If you need additional space please use back of form

MEDICATION NAME	DOSAGE

Do you have any known Allergies to Medication? € Yes € No

If so, please list medication and reaction: _____

_____

FAMILY HISTORY

Do any family members have any of these conditions? If so who?

	Parents	Siblings	Aunts	Uncles	Cousins	Grand Parents
Allergies						
Arthritis						
Asthma						
Bleeding Disorder						
Cancer (type)						
Cystic Fibrosis						
Diabetes						
Drug Abuse						
Epilepsy						
Heart Disease						
High Cholesterol						
High Blood Pressure						
Kidney Disease/Stones						
Mental Illness						
Obesity						
Osteoporosis						
Stroke						
Suicide						
Thyroid Disease						

SOCIAL HISTORY

Occupation: _____

Education: _____

General Stress Level: € Low € Medium € High

Exercise Level: € None € Occasional € Moderate € Heavy

Diet: € Regular € Vegetarian € Began € Gluten Free € Specific Carbohydrate or Cardiac

Marital Status: € Married € Single € Divorced € Separated € Widowed € Domestic Partner € Unknown

Smoking Status: € Never Smoked € Former Smoker € Current Every Day Smoker € Current Some Day Smoker

Smoking How Much: € None € 1 PPW € 2 PPW € ¼ PPD € ½ PPD € 1 PPD € 1 ½ PPD € 2 PPD € 3+ PPD

Alcohol Intake: € None € Occasional € Moderate € Heavy

Any Past Use of Illicit Drugs: € Yes € No

Sexual Orientation: € Heterosexual € Homosexual € Bisexual

Assigned Sex at Birth: € Male € Female

REVIEW OF SYMPTOMS

Review of Symptoms (Check any of the following which you have now or have experience in the past.)

	NOW	PAST
GENERAL		
Nausea		
Recent weight gain or loss		
Fatigue		
Fever/chills/night sweats		
CARIOPULMONARY		
Heart Murmur		
Palpitations		
Chest Pain		

	Shortness of Breath		
REVIEW OF SYMPTOMS CONTINUED		**NOW**	**PAST**
	Wheezing		
	Chest tightness		
	PSYCHOLOGICAL		
	Schizophrenia		
	Depression		
	GASTROINTESTIONAL		
	Indigestion/heartburn		
	Vomiting		
	Change in stool color		
	Diarrhea/Constipation		
	Abdominal Pain		

SIGNATURE: _____ DATE: _____